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Washington State Behavioral Health During Pregnancy Discovery Sprint

Research and Recommendations

Bloom Works, LLC

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Discovery Sprint Final Report: Behavioral Health during Pregnancy

Executive summary

This report presents the findings and recommendations from the discovery sprint that Bloom Works conducted between May-August 2024, aimed at improving behavioral health access and outcomes for pregnant and parenting individuals using substances. This project was undertaken to provide insights for the Children and Youth Behavioral Health Work Group (CYBHWG) and to inform the Prenatal-25 Behavioral Health Strategic Plan.

In collaboration with the Health Care Authority (HCA), this discovery sprint explored the experiences of pregnant and parenting people who use substances and how they navigate the behavioral health system, as well as the perspectives of staff that serve them on the front lines, and professionals who oversee the systems that organize and deliver these services.

Based on this research, the discovery sprint presents these insights about experiences for both people with lived experience as well as service providers:

- Fear of CPS stops pregnant people from getting help and makes it harder for providers to know when to report.
- Despite widespread recognition for whole-family care, operational barriers make it nearly impossible for providers to offer it, burdening those with lived experience.
- Peer navigation work is crucial yet under-resourced, despite the growing recognition of the value of lived experience.
- Direct service organizations can do more with increased support.

Recommendations, based on these insights:

- Overarching recommendation: Increase focus on prenatal substance use as a strategic priority
- Decouple CPS from getting help
    - Iterate on Plan of Safe Care (POSC)
    - Provide essential information to families involved with CPS
    - Expand decision support resources for people who are reporting to CPS
    - Develop a "harm reduction" model for doula reimbursement
    - Emphasize local administration and independence from DCYF in CPS prevention efforts.
- Expand pathways to whole-family care
- Continue to expand opportunities for peer navigation/ally roles
- Increase support for direct service organizations
    - Encourage behavior change through information sharing and networking

- Increase support for emerging or expanding providers

Acknowledgements

This work is powered by people with lived experience and subject matter expertise, who contribute immense compassion and brilliance to improve outcomes for pregnant and parenting people who use substances. While we intentionally anonymize our sources, we want to give special recognition— with permission—to our thought partner, Sarah Korkowski, who contributed significantly to many recommendations.

Despite incredible obstacles, the people with lived experience that we heard from are ones who have better outcomes than many of their peers because they managed to get meaningful support and reunite with their (younger) children. Our value of centering the perspectives of people with lived experiences goes beyond prioritizing their voices in our work — it also means acknowledging that many people are still struggling with addiction, have never reunified with their children, are incarcerated, and/or have died. We acknowledge that these people were and will continue to be impacted by these challenges, and this work won't be enough to support them as needed.

We also acknowledge the enormous efforts from healthcare and direct service providers, as well as advocates from local communities to legislative officials, that work tirelessly to improve the conditions and outcomes of people with lived experience and their families. Some efforts have yielded positive outcomes, while others have fallen short. It's crucial to keep refining and iterating to better serve those who are still impacted by these challenges.

Research scope and approach

Background and scope

The interconnectedness of substance abuse, mental illness, and CPS involvement are well documented. 2023's Washington State Maternal Mortality Review Panel: Maternal Deaths 2017-2020 asserts that 30% of deaths due to accidental substance use overdose are pregnancy related.

A 2020 study from the National Center on Substance Abuse and Child Welfare shows that 41 - 50% of children in Washington are removed from their homes by CPS because of substance use exposure.

Results from a 2019 national survey and accompanying report estimates that parents with serious mental illness are about eight times more likely to have contact with CPS. The study also considers how factors like poverty and discrimination help explain why parents with serious mental illness have higher rates of CPS involvement.

Early stages of the discovery sprint process uncovered that access and usage of behavioral health services — across stages of pregnancy and parenting — is a critical area where we need to understand the root causes and human experiences within the system.

At the same time, other critical issues revealed that a discovery sprint framework is not well suited to investigate — for example, the limited supply and availability of residential treatment facilities. This is a clear and widely acknowledged need, since meaningful behavioral health outcomes require services to be available and appropriately funded, and this supply issue is largely a reflection of funding, policy, and economics. In other words, the need and root causes are already well understood, and discovery would not meaningfully move this issue closer to solution.

The scoping process for this discovery sprint began with a broad question: ***How might we provide more successful behavioral health supports for pregnant and parenting people to keep families together?***

Scoping interviews with about a dozen subject matter experts and stakeholders highlighted various challenges within this issue, including:

Lack of available services: There is a notable shortage of behavioral health services tailored to the needs of pregnant and parenting adults. Scoping interviews underscored the closure of many residential substance use treatment programs due to funding issues.

Lack of family-centered services: There is a deficiency in whole-family and family-centered services. In addition to residential facilities closing, few residential treatment programs allow whole families to stay together throughout treatment.

Access barriers: Pregnant and parenting individuals face significant obstacles in accessing existing behavioral health services, including inconvenient locations, long wait lists, limited hours of operation, and restrictive enrollment and retention rules (e.g., substance use disorder treatment programs that do not admit children or partners).

Stigma, fear, and lack of trust: Seeking behavioral health services, particularly substance use disorder treatment, while pregnant or parenting is stigmatized. Additionally, there is a prevalent fear among individuals that seeking such services may trigger child welfare involvement due to mandated reporting. The lack of peer support from people with lived experience compounds these experiences.

Holistic support needs: There is a need to address the basic needs of pregnant and parenting individuals beyond immediate behavioral health services, such as housing, transportation, and food access. Not having these needs met were repeatedly identified as critical barriers to successful support.

Preconception wellness: Promoting wellness and addressing access barriers and systemic factors before conception is crucial.

We evaluated different timeframes (preconception, pregnancy, and post-birth) for potential focus areas. This discovery sprint concentrated on the pregnancy stage due to several compelling reasons:

Motivating factors: It is well understood that pregnancy often motivates individuals to seek care and services. Pregnancy also offers increased touchpoints with medical care and opportunities for intervention. Scoping interviews referred to the potential to see pregnancy

as "*an opportunity rather than a barrier… [and a] time for more services, more engagement, and a pivot toward more positive outcomes.*"

Unique barriers: There are specific barriers and gaps in accessing specialized behavioral health-related services during pregnancy. These barriers exist for pregnant people (as highlighted in the previous section) and for providers. For example, multiple interviews mentioned that some substance use treatment providers don't feel confident or comfortable treating pregnant people.

Opportunity for preventive/upstream interventions: After childbirth, individuals face numerous behavioral health challenges, including child welfare involvement and maternal and infant mortality, as well as difficulties in accessing services. **While there are critical behavioral health issues unique to post-birth, this sprint focused on pregnancy as a strategic point for early intervention to promote wellness and prevent negative outcomes.** While interventions before pregnancy are also essential for improving wellness, addressing behavioral health *during* pregnancy is crucial due to the immediate and acute needs present at this stage.

The resulting focus question for this discovery sprint:

> ***How might we better connect people who are pregnant and experiencing behavioral health concerns including, use of substances, to services while pregnant?***

What this work is and is not

This research focuses on the realities of pregnant and parenting people who use substances, which is connected to, but is only one of many facets of, behavioral health. Our focus on pregnancy is to maximize opportunities for preventing the most harmful outcomes that people with lived experience face.

This work is not intended to speak to all the critical needs and current efforts to augment behavioral health supports in Washington state. Nor is it meant to devalue any other phases of the perinatal journey, which are interconnected and equally important.

About the discovery sprint approach

Discovery sprints are short, focused research projects designed to quickly understand a specific challenge and identify actionable paths forward. They are time-bound and fast, and require a narrow scope so that you can find actionable, concrete opportunities.

This methodology is a qualitative approach ideal for exploring why certain issues exist, how existing processes happen, identifying root causes, and uncovering opportunities to address them. However, discovery sprints cannot solve historically systemic issues or provide exhaustive findings within a 10-week timeframe. They also cannot answer all questions on a topic — often they generate additional questions for further exploration.

What we did

This was a 10-week project between May-August 2024, that included 6 weeks of research interviews. Through the process we worked closely with the Strategic Plan Advisory Group (SPAG) co-chairs and the Health Care Authority (HCA), checking in regularly to ensure alignment and gather feedback.

Who we talked with

Our research involved engaging with a diverse range of individuals connected to the healthcare and behavioral health systems. We reached out to people with lived experience as well as professionals working on the front lines or in leadership roles within the system:

State system agencies and partners: 20 individuals involved in administering the state's healthcare and behavioral health systems.

Professional advocacy organizations: 6 representatives from organizations focused on advocacy and policy.

Behavioral health service medical providers and direct service providers: 21 people including healthcare providers, mental health specialists, and direct service providers.

Non-clinical supports: 9 individuals who provide non-clinical support, including navigators, counselors, and allies.

People with lived experience: 26 individuals, including participants with lived experience that spoke with us in their professional roles.

Centering lived experience

Our approach emphasized centering the voices of people who are pregnant and experiencing behavioral health concerns, including substance use. We particularly sought input from individuals who had successfully connected with meaningful support and were able to reunify with their younger children. On a practical level, we wanted to learn how people with lived experience got connected to meaningful support. On an ethical level, it did not feel appropriate to potentially disrupt the recovery process for someone with an active addiction and/or managing an open CPS dependency case. We recognize that this focus excludes individuals who are currently struggling with addiction, have not been able to reunite with their children, are incarcerated, or have passed away.

Acknowledging the landscape of interconnected challenges

Numerous large-scale systems have contributed to these challenges and may be beyond direct control, including, but not limited to:

- High rates, severity, and newness of fentanyl use for which there is inadequate response and support,

- Workforce shortage for all healthcare professionals, especially nurses and behavioral health workers,
- Housing crisis that disproportionately impacts low-income and historically disadvantaged communities,
- Medical care and systems that reinforce specialization and treatment silos, and
- Healthcare structures that are largely driven by the business models of insurance companies which encourage quantity over quality, leading to insufficient face-to-face time between providers and patients and one-size-fits-all solutions that do not effectively meet the needs of people that are the most vulnerable.

These are the 'givens' — we need to acknowledge that our insights and recommendations live with this context, but we're not addressing these in the scope of this report.

Key insights

Insight 1. Fear of CPS stops pregnant people from getting help and makes it harder for providers to know when to report.

Insight 1A. The fear of CPS can prevent people who are pregnant and using substances from seeking help.

Unless someone has engaged with CPS in the past or has someone that can help them through, the process is a black box. They don't know what to expect or how to navigate it.

Those who have had previous experiences (like a previous case or their own childhood) are likely to have deep rooted skepticism and fear of the process..

There's a sense that sharing any detail about who they are or their lives could trigger a report to CPS — one person with lived experience said she was unsure if disclosing that she's dyslexic would separate her from her baby. Even when an investigation cannot be initiated until birth, the fear of a CPS report can prevent people from seeking prenatal care.

Insight 1B. Engaging with services through CPS can be fraught.

When a person accesses programs and services through CPS and starts to do well, they can lose access to the resources that are keeping them stable. Some people only get support for concrete goods like the Family Unification Program (FUP) voucher if they are CPS involved. But once their recovery improves — which is everyone's goal — CPS will close their case, taking away the FUP voucher and all the benefits tied to CPS. This makes it much more likely for CPS to get involved again in the future. Likewise, CPS might determine that a situation is too high risk for a baby to stay with their parents, but at the same time, the situation isn't high risk enough for the parents to qualify for benefits that provide more stability and make reunification possible.

Even when a program or service is trusted, the looming threat of mandatory reporters can prevent them from being honest about what they might need.

> *"I was really scared when I heard CPS was going to be a thing because I know* ***some people get really bad CPS workers and even though they're doing really good, some stupid little thing will affect everything."***
>
> *Person with lived experience*

Experiences with CPS, as well as with healthcare providers, can be inconsistent and very dependent on the person assigned. On the one hand, we heard stories of incredible workarounds and the long arm of empathy: one person can make all the difference for a person with lived experience.

> *" I told the doctor who delivered the baby that I was terrified that if I left, I was gonna go use and I wouldn't come back for my baby. And so she kept making excuses to keep me admitted so that I could discharge with my baby to [a support organization with housing]."*
>
> *Person with lived experience*

On the other hand, the lack of systematized support further adds to the lack of transparency on knowing what to expect when encountering CPS and knowing exactly what your rights are and are not.

> *"There's such a misunderstanding of what people's roles and jobs are. We work with medical providers who believe CPS can actually help someone access services. They don't realize the person coming out is a CPS investigator – not there to offer services. They will tell you otherwise, but they are lying."*
>
> *Subject matter expert*

There is a critical lack of transparency with how CPS involvement works and what people with lived experience can expect. The only people with lived experience whom we heard from that were able to navigate the process had learned this through the absolute worst scenario: they had done it before and lost custodial rights to their older children, in many cases, permanently.

Insight 1C. It is difficult to know when to report to CPS.

The vast majority of services for people with lived experience come by way of CPS. Some of the best examples of whole person and whole family care are only offered through CPS referrals. This not only erases the opportunity to *prevent* CPS involvement, it also counteracts the need for more support services that are not involved with CPS.

> *"I'm banging my head against the wall currently with some of the contract managers at the county over housing programs and over treatment resources that will only take referrals from DCYF….I'm contracted with [a public agency], I'm involved in this case, yet I cannot submit a referral.' …I have parents who will not sign an ROI with DCYF and you know, it's a really tricky spot to be in* ***because the same people that are offering you the care and support to get your kids back are also the ones that are trying to or have taken your children away.****"*
>
> *Person with lived experience, subject matter expert*

Plan of Safe Care (POSC) is a new attempt by DCYF to introduce a decision tree at birth in hospital settings to divert potential reports that do not indicate risk of safety to the child towards community pathways. Outside of hospital settings where POSC has been implemented, there isn't enough guidance on when a circumstance warrants a report to CPS. Mandatory reporters are more likely to file a report due to the risk of losing their license or being charged with a gross misdemeanor. Providers who leverage people with lived experience shared similar approaches when calling CPS:

- Calling CPS is a last resort when other options have been exhausted or a danger is imminent.
- Calls to CPS are made in collaboration with the client with a commitment to stay before, during, and afterwards.

> *"It is very difficult to get a hold of Plan of Safe Care community based pathway clients even though they've given consent. And there is* ***so much fear and stigma even though this is diversion and prevention away from CPS, that fear is so strong within clients in this community that we still can't get a hold of them after they've had a baby.****"*
>
> *Subject matter expert*

Programs and services that only take referrals from CPS can present limitations for entry (both for recently parenting people and direct service organizations that are trying to help). Even in the case of POSC, wherein a pregnant person will be screened out because the child is not yet born, they must still interact with CPS in order to not interact with CPS. This is a high risk for a person with lived experience, despite the attempt of CPS to do the opposite. The simplest way to offer community based services for people with lived experience is to offer them directly, without the intervention of CPS.

Insight 2. Despite widespread recognition for whole-family care, operational barriers make it nearly impossible for providers to offer it, burdening those with lived experience.

> *"it's certainly more approachable for families if they can go through this process together, whether you're, and sometimes we've had moms, I mean, we have single dads, single moms, but we also have whole families that come in or like maybe one partner comes in later than the other. And you know, it's, you see, you see the stability increase, usually not every time, but usually you see that when a family is, is reunified and the members can come together and live together and go through the program together."*
>
> *Subject matter expert*

When families can enter and carry out treatment together, not only do they tend to have a shorter and easier recovery process with longer lasting positive outcomes, they are also afforded treatment that is more cross-culturally informed. Dominant culture, which is rooted in and privileges whiteness, often normalizes individualism rather than collective care, when the latter reflects values that are inveterate to many people of color. By offering whole family options, the barriers for entry are not only diminished in the immediate and literal sense but also reduce alienation that many people of color might experience.

Insight 2A. Barriers to whole family care result in impossible choices

> *"One of the dads said, 'I feel like I'm in a position where they're slipping me services on the side like they're gonna get in trouble if they support me.' This is a CPS involved family where both parents were using, but CPS was working really heavily with mom to get her clean and sober. And dad was saying, 'But I want to be a resource. I want to support her. I want to support the baby. I want to be here for my child.' And the worker would say, 'Well, here's some things you could do... You know, don't tell anybody that I'm doing this.'* ***He said it was just incredibly clear that he wasn't the focus.*** *"*
>
> *Subject matter expert*

CPS does not always acknowledge the second parent/father as a person who might need support. Treatment options that are whole-family centered tend to have lower rates of recidivism, make recovery sustainable, and decrease the negative outcomes from family separation and the high costs of 'revolving door' scenarios for both clients and their providers.

Currently, few options allow a family unit (caregivers, children) to stay together in treatment. This can result in:

- A choice between getting treatment or caring for their child(ren),
- One parent getting treatment while the other does not,

- Treatment that does not treat the family and is not culturally competent,
- Partners/fathers being deprioritized as a meaningful part of the family unit which increases the likelihood of single parenthood for the birth parent, and/or
- Reports of being asked by a program to leave children with other parents in recovery, rather than with childcare staff.

Insight 2B. Operational barriers prevent whole-family care

Individual family needs and access to resources can create barriers to providing whole family care.

For example, supporting multiple genders can be complicated. When a parent and child are of different genders, separating genders in certain settings can create difficulties. Ensuring privacy for families in these situations can also be challenging.

Hosting on-site childcare adds another layer of complexity. Childcare requires its own set of licenses, physical spaces, and staff, making it a distinct business from other services. Additionally, providing whole-family care can be expensive. A notable example of success in this area, Rising Strong, is often seen as exceptional and hard to replicate. This is due to their heavy dependence on private and community-based funding, which isn't always scalable. State funds intended to support whole-family care have previously been allocated in ways that were too restrictive or complex for providers to use effectively.

Insight 3. Peer navigation work is crucial yet under-resourced, despite the growing recognition of the value of lived experience.

Insight 3A. Peer navigation work is critical and under-resourced.

The landscape described at the beginning of this report foregrounds the prevalence of pregnancy and substance use — a problem that exists and is worsened from the gaps in our institutional systems. We repeatedly heard from people with lived experience that their doulas, especially ones with lived experience themselves, and peer navigators were the ones to meet them where they were at in their recovery process, leading to more successful treatment outcomes. A critical piece of meeting people where they are at in their addiction and recovery process includes meeting them *when* they are ready to receive treatment:

> *"I got all my stuff ready. I'm ready to go to treatment and the bus never shows up, and then the taxi I called never shows up to take me there. So after like 30, 40 minutes of waiting, I was like, 'Fuck this, I'm going home, I'll go tomorrow.' But you know, had I stayed that night at home, I wouldn't have gone back. At home my doula called me and was like, 'We gotta go. If you're gonna go, we gotta go now.' And I was like,* ***'I'm just gonna wait til tomorrow. I just wanna stay at home for one night.' And she was like, 'You can't, I mean, you can if you want, but there's not gonna be a bed for you tomorrow, you know?' I packed my stuff and I went after my doula gave me a ride."***

> *Person with lived experience*

The speaker above echoed others we heard from when she told us that had it not been for her doula who provided emotional and transportation support, all without threatening her autonomy, she likely would not have made it into treatment that day, which would follow with a cascade of negative outcomes.

A key element of the relationship between individuals with lived experience and their doulas or peer navigators is that the doula or peer navigator is often the only person with whom they can be completely themselves, particularly when the threat of mandated reporting is not present. This is not only emotionally fulfilling but also plays an enormous role in treatment and caring for physical health, which depend on being fully honest.

This makes it clear that doulas and/or peer navigators are often the invisible link to accessing the services that these facilities were designed for. The strengthening and expansion of these supports are therefore critical.

> *"But what if there was certified peer counselors within Medicaid with each individual Medicaid? So,* ***if somebody is pregnant they automatically get a certified peer counselor through Medicaid that goes through all of it with them and never has to stop.****"*
>
> *Person with lived experience*

Peer navigators also play a motivational role, especially for those who are earlier in their recovery journey, as they represent a potential career path and a future possibility. However, accessing peer navigators can be limited to specific pathways, and much of their work is either unpaid or underpaid.

Insight 3B. Growing recognition of people with lived experience

> *"When you hear that from the people you're actually engaged with and stop, like, looking up stuff online or reading it in like a medical report, it's like, 'hey, people are telling you what they need and how they would like to be engaged with and what was helpful or not helpful.* ***We could just take a pause and like, they could teach us like, we don't need to have these panels, we don't need to have these big, like, you know, conventions where we talk about addiction medicine unless we just have panels of experienced people****, who have engaged with these systems and they can tell you what worked and what didn't and we* ***make sure that they get paid every time.****"*
>
> *Person with lived experience, subject matter expert*

Direct service organizations frequently hire individuals who have previously gone through their programs to act as peer advocates. Those with personal experience in the programs are often more

successful at building trust and maintaining engagement with others using the services. Many of these organizations emphasize how crucial it is to get feedback directly from people with lived experience to enhance their programs and services.

Insight 4. Direct service organizations can do more with increased support.

Insight 4A. People experience barriers before receiving help.

> *"I think that home visits provide kind of a unique opportunity to literally meet people where they are. Our healthcare system is not designed to have facilities where they are most needed, but instead our facilities are where they are convenient for us, and that* ***asks our most vulnerable populations to make the greatest sacrifice in order to receive the care that they need.****"*
>
> *Subject matter expert*

Navigating the path to accessing help can be fraught with challenges for people seeking support. When people who are using substances become pregnant, they face abandonment by their community and personal connections, heightening their risk of withdrawal, and posing serious risks to both their own health and that of their baby. Seeking help requires them to overcome expectations of being treated with judgment and shame, or fears of being reported to CPS or the police. There are few options that accommodate pregnant people who are using substances, as many OB providers lack expertise in SUD, and substance treatment programs lack expertise in pregnancy.

If a person is able to find a program or service that will accept them, they must navigate restrictive service hours, long waitlists, and stringent entry criteria. While it's widely recognized as best practice to capitalize on the moment someone is ready to accept help, most programs and services are not equipped to meet individuals where they are at that precise moment, which often means that the person who is seeking help will not return.

Insight 4B. People experience barriers while receiving help.

> *"Imagine if we treated diabetics like we do [people who are using substances]. Like, 'we'll give you insulin when you stop eating all carbs and exercise every day for an hour.'"*
>
> *Person with lived experience, subject matter expert*

Many individuals face significant barriers when accessing treatment, including a lack of support for essential needs such as transportation, housing, childcare, pet care, storage, and inclusive

treatment for additional children or partners. Additionally, experiences of judgment, shame, and dismissive treatment can undermine their efforts and leave them feeling disempowered.

> *"No one can judge us or make us feel worse than we do ourselves - we don't need to feel it from the people who we are expecting to help us. We don't need outside judgment. We know what we did to our babies and we have to deal with that for the rest of our lives."*
>
> *Person with lived experience*

Stigma and fear of CPS are the bulk of what prevents pregnant people using substances from prenatal care, which tends to result in traumatic births in emergency departments with doctors and nurses whom they've never met. As the speaker informs, people with lived experience know that using substances while pregnant puts their babies at risk, and it is not as simple as stopping substance use when you know it is harmful. This emphasizes an urgent need for a deeper understanding of addiction across providers not only in healthcare, but in direct service roles as well.

One person with lived experience spoke about an experience at a hospital where the staff repeatedly tried to take the baby's umbilical cord for testing even though they did not consent.

Often, the help provided does not address underlying issues, such as behavioral or mental health needs, stable housing, food insecurity, material goods, transportation, or stable income.

Once a program ends, it may do so abruptly without warning, even if the individual continues to face challenges like houselessness. Moreover, warm hand-offs between services are not consistently provided, leaving gaps in support and continuity for those who are still in need.

Furthermore, once CPS is involved in a case, their first move tends to be separation, even when the goal is reunification. Not only is this a contradiction that many people with lived experience find troubling, it also exacerbates the birth parent's journey toward recovery:

> *"In the beginning, you get better for your kids, you don't do it for yourself because you have no self love. You have no self respect, you have no self worth - nothing. So in the beginning, it's 100% for your kids. So when they remove your children from you, it's like, 'What's the point? What is the point? Because you just took away my reason for living.'"*
>
> *Person with lived experience*

Insight 4C. Direct service organizations are operating in a resource constrained environment.

> *"...**when there is not enough funding, you tend to be really competitive**. So everybody's trying to do what they can to maintain those programs. So if there were more funding, we can collaborate more and not being worried about losing our program. So it's basic social justice."*
>
> *Subject matter expert*

Funding opportunities for direct service organizations are often difficult to navigate and typically cover only part of the costs, without supporting program growth or maintenance. This limited and restrictive funding tends to create competition rather than fostering collaboration. Whereas, if organizations were fully funded or incentivized to work together, it could result in better transitions for people with lived experience after a program or service ends. Organizations also face challenges with chronic understaffing, high staff burnout, and turnover, which affects their ability to expand services or engage in outreach.

Operating at full capacity restricts their ability to grow, and the lack of specialized staff expertise further complicates their efforts. Many organizations value the ability to call the Perinatal Psychiatry Consultation Line (PPCL) for specialized support. However, they often have limited time and resources to build relationships or connect with relevant local organizations, and much of their work is done without compensation.

Immediate needs frequently take priority over long-term investments like staff training. There is also a lack of training for non-medical roles, and navigating complex rules and regulations can be challenging, especially for new programs. Identifying those in need often relies on self-disclosure, so programs and services must be prepared to offer support as soon as it's needed.

Recommendations

Increase focus on prenatal substance use as a strategic priority.

Why this matters: Opportunities during this period are often overlooked in the prevention services ecosystem and among strategy and intervention efforts.

Timeframe: Near-term

Potentially responsible: CYBHWG and SPAG

Opportunities for action

- Prenatal substance use services and supports are crucial for improving outcomes post-birth, including reducing CPS involvement, family separation, and maternal mortality.
- This topic is generally overlooked in Washington's behavioral health discussions due to the complexity and time-sensitive nature of pregnancy.
- Strategy discussions recognize the need for interconnected care for both parent and child starting in pregnancy. However, healthcare and behavioral health systems often treat prenatal and postpartum stages separately, resulting in a "fracturing of care" rather than integrated continuum of care.
- **Potential path forward**: The P-25 strategic plan should include prenatal substance use as an early intervention opportunity.

Rec 1. Decouple CPS from support services.

Why this matters: The ability to meet people where they are at and when they are ready for treatment could radically increase if, wherever feasibly possible, the fear of CPS and mandated reporting are reduced when accessing services.

Related insights:

1. Insight 1A: The fear of CPS can prevent people who are pregnant and using substances from seeking help
2. Insight 1B. Engaging with services through CPS can be fraught
3. Insight 1C: It is difficult to know when to report to CPS

Rec 1A. Iterate on Plan of Safe Care (POSC)

Why this matters: By truly bridging people with lived experience with community supports, the threat of or actual involvement of CPS could be reduced. Removing CPS from POSC could simplify the process, as well as reduce fear and uncertainty for people with lived experience.

Timeframe: Near-term

Potentially responsible: DCYF

Opportunities for action:

- Consider adding a trained third-party to triage potential cases. This is in contrast to a healthcare professional making a determination based on the POSC portal.

Rec 1B. Provide essential information to families involved with CPS.

Why this matters: Helping families navigate the process more effectively can potentially shorten the length of time in which they are involved with CPS, as well as, increase the likelihood of success.

Timeframe: Near-term

Potentially responsible: DCYF + Legislature

Opportunities for action:

- Assign a non-CPS person to help families navigate the process (e.g., similar to First Clinic Peer Advocates).
- Distribute digital and **physical** copies of rights, expectations, and resources to every family involved with CPS, including:
    - What might trigger a CPS report,
    - How screened-out reports are managed and used, and
    - Information on Voluntary Placement and Voluntary Services.
- Make all information accessible online and in locations frequented by people that might need it (e.g., needle exchange sites).

Rec 1C. Expand decision support resources for anyone who calls CPS.

Why this matters: Making clear resources available online and in print can reduce unnecessary CPS calls by directing people to community alternatives.

Timeframe: Long-term

Potentially responsible: DCYF + Legislature

Opportunities for action

- Publish clear, accessible CPS reporting guidelines, including alternative ways to support families, in both digital and print formats for callers.
    - Market information in any setting where someone might be compelled to report about a family.
- Create a warmline to function as decision support for people who aren't sure whether or not a report to CPS is warranted.
    - Staff the warm line with people with lived experience and share resources that may be helpful to a family that does not require a CPS referral.
- Explore what other states are doing to provide guidance to CPS reporters (see NPR article: States find a downside to mandatory reporting laws meant to protect children).

Rec 1D. Develop a "harm reduction" model for doula reimbursement.

Why this matters: Enabling doulas to work in a patient-centered manner while addressing concerns about their role as mandatory reporters is crucial, especially with the rollout of the Apple Health doula benefit in 2025 (see Doulas on the WA HCA website). Although the benefit presents a significant opportunity to support individuals, the expectation that doulas will be considered mandated reporters could potentially hinder doulas' ability to provide a safe and supportive environment.

Timeframe: Near-term

Potentially responsible: HCA + DCYF + DOH

Opportunities for action:

- Explore how other states have approached doula certification and mandated reporting.
    - e.g., Only the State of Nevada has specifically named doulas as mandated reporters (see report from the Colorado Protection Ombudsman).
- Consider ways to subsidize doula support for people with lived experience without qualifying them as "medical providers" so that they are not automatically mandated reporters.
- Find ways to ensure children's safety without increasing the difficulties faced by their birth parents due to mandated reporting.

Rec 1E. Emphasize local administration and independence from DCYF in CPS prevention efforts.

Why this matters: Increase trust among people with lived experience and providers that prevention resources are there to be helpful and will not trigger CPS.

Timeframe: Long-term

Potentially responsible: DCYF + Legislature + TBD

Opportunities for action:

- Increase trust among people with lived experience and providers that prevention resources are there to be helpful and will not trigger CPS.
- Consider shifting funding of state programs to local initiatives and community-based organizations (some of which is already ongoing).
- Understand how people with lived experience perceive and engage with DCYF's prevention services.
    - Evaluate who the programs are serving and what populations are not being reached.

Rec 2. Expand pathways to whole-family care.

Why this matters: Partners/fathers should be able to enter treatment with the birthing parent during pregnancy, and once the baby is born, both parents should be able to enter and continue treatment together, including the baby and any older children.

Related insights:

- 2A: Barriers to whole family care result in impossible choices
- 2B: Operational barriers prevent whole-family care

Timeframe: Long-term

Potentially responsible: CYBHWG and Strategic Plan

Opportunities for action

- Encourage programs to scale incrementally towards whole-family care (rather than all at once).
- Further investigate challenges related to childcare in existing program settings.
- Continue to investigate ways in which legislation, rules, and guidance might be marginalizing partners/fathers.
- Encourage program development that treats partners/fathers specifically.
- Investigate increasing minimum length of stay requirements through legislation that are longer for people who have used substances during birth.
- Investigate ways to keep the birth parent and baby together in a hospital setting (rather than holding the baby for observation and discharging the parent that has just given birth).
- Investigate how to encourage whole-family care through grants issued to Certified Community Behavioral Health Clinics (CCBHC).

Rec 3. Continue to expand opportunities for peer navigation/ally roles

Why this matters: Equipping people with lived experience with more peer-level supports will help them navigate the system, understand options, connect to services, and imagine a future life in recovery.

Related insights:

1. 3A: Peer navigation work is critical and under-resourced.
2. 3B: Growing recognition of people with lived experience.

Timeframe: Long-term

Potentially responsible: CYBHWG and Strategic Plan

Opportunities for action:

- Encourage different skilled pathways for peer advocates (both medical and non-medical) that enable more programs and services to employ people with lived experience.
- Encourage programs and services to employ peer support throughout the delivery of services, and especially at the point of outreach and entry.
- Increase access to prenatal peer support, particularly for the Medicaid population.
- Formalize the support peer navigators already often provide.
- Support peer advocates with mental health support and training.

Rec 4. Increase support for direct service organizations

Why this matters: More opportunities for prevention and treatment are critical, and without more service providers, the current problem will not reduce and could actually get worse.

Related insights:

1. 4A: People experience barriers before receiving help.
2. 4B: People experience barriers while receiving help.
3. 4C: Direct service organizations are operating in a resource constrained environment.

Rec 4A. Encourage behavior change through information sharing and networking.

Why this matters: If direct service organizations are encouraged to enhance their skills and knowledge, and to build relationships and networks with one another, people with lived experience could benefit from more coordinated and connected care across the different entities.

Timeframe: Long-term

Potentially responsible: CYBHWG and Strategic Plan

Opportunities for action:

- Employ people with lived experience to tell their stories and train people in support roles (not just healthcare).

- Publish a best practice playbook with guidance on how to best reach and treat this population.
- Encourage training in relation to treatment for fentanyl.
- Facilitate relationship-building through state and regional convenings.
- Expand successful programs to broaden access to specialized care in pregnancy and substance use (e.g., Perinatal Psychiatry Consultation Line [PPCL], ECHO model).

Rec 4B. Increase support for emerging or expanding providers

Why this matters: By bolstering support for providers who are new or expanding, especially in areas of need, the state could improve access to services for people that need them the most.

Timeframe: Long-term

Potentially responsible: CYBHWG and Strategic Plan

Opportunities for action:

Increase support for new or small providers to establish or grow programs and services:

- Staff a person who is responsible for the provider experience (e.g., Chief Experience Officer for providers).
- Pilot a navigation service to educate about funding, insurance, regulations, and policies.
- Host an "integrated service incubator" to connect and co-locate new and small behavioral health programs and services for comprehensive care. The incubator could provide seed-funding and connection to other providers, while delivering care to people.

Conclusion

Addressing these issues requires increasing transparency around CPS processes, expanding whole-family treatment options, improving support for doulas and peer navigators, and ensuring direct service organizations have the resources they need. As mentioned earlier, discovery sprints are an excellent method for broadly researching a topic. Each of these requirements needs further exploration to determine how implementation might unfold. By focusing on these opportunities for improvement in the system, the State of Washington can better support pregnant individuals dealing with substance use and improve their overall health and outcomes.

Appendix A - Key terms and acronyms

Child Protective Services (CPS): An agency within the Department of Children Family and Youth, responsible for protecting children from abuse and neglect by investigating reports and intervening to ensure child safety.

Children and Youth Behavioral Health Work Group (CYBHWG): Provides recommendations to the Governor and the Legislature to improve behavioral health services and strategies for children, youth, young adults, and their families.

Department of Children Family and Youth (DCYF): A department of the state that houses CPS.

Harm reduction: An approach that focuses on minimizing the negative effects of risky behaviors rather than trying to eliminate the behavior completely. Ex. Instead of saying "don't use drugs" offer needle exchanges and evidence-based guidance on safe drug usage.

Neonatal Opioid Withdrawal Syndrome (NOWS): Newborns experiencing withdrawal from opioids that span prescriptions to illicit substances.

Perinatal Psychiatry Consultation Line (PPCL): A free, state-funded program providing perinatal mental health consultation, recommendations and referrals for Washington state providers caring for pregnant or postpartum patients.

Person/People with lived experience: A pregnant or parenting person who used substances while pregnant.

Plan of Safe Care (POSC): An effort from DCYF to screen cases away from CPS into community pathways of support.

Strategic Plan Advisory Group (SPAG):Made up of young people (ages 13-29), parents and caregivers, and system partners, working together to find common ground and develop collective discussions.

Appendix B - Annotated works consulted

This list includes an overview of the foundational materials that informed the report's findings and recommendations.

1. Washington State Maternal Mortality Review Panel: Maternal Deaths 2017–2020; (Bat-Sheva Stein, DNP, MSN, MSc, et al. Washington Dept. of Health, 2023)
    a. Since 2016, Washington's Maternal Mortality Review Panel has analyzed pregnancy-related deaths to identify preventable causes and disparities, finding that 80% of such deaths were preventable, often due to issues like behavioral health and systemic bias. They recommend improvements in healthcare access, quality, and support, particularly for BIPOC and low-income communities.
2. Prenatal-25 Behavioral Health Strategic Plan - December 2023 update
    a. In 2022, Washington's legislature authorized a new strategic plan to improve behavioral health services for people from pregnancy through age 25 aka "P-25 Strategic Plan." This plan aims to create a comprehensive, equitable system by identifying gaps, leveraging best practices, and coordinating efforts across agencies, with a draft due to the Governor and Legislature in 2025.
3. 2024-01-15_P-25 Strategic Planning Concept_with Appendices
    a. Further details on the P-25 Strategic Plan's vision, commitment to input from people with lived experience, opportunities for philanthropic contributions, and high level goals.
4. National Center on Substance Abuse and Child Welfare (ncsacw.acf.hhs.gov, 2020)
    a. Visual aids showing the correlation between child welfare involvement and substance use. Nationally, 39% of children placed in out-of-home care had parental alcohol or drug abuse listed as a reason, but state data can vary widely. Discrepancies between reported data and actual conditions might be due to inconsistent screening, data entry practices, or differences in how reasons for removal are recorded and reported.
5. Child Protective Service Disparities and Serious Mental Illnesses:Results From National Survey; (*Psychiatric Services* 70:3, Mar. 2019)
    a. This study found that parents with serious mental illness are significantly more likely to have contact with child protective services (CPS) and face more severe outcomes, such as custody loss, compared to parents without mental illness. It highlights the need to better support and understand the challenges faced by

parents with mental illness to reduce their CPS involvement and improve outcomes for families.

6. The Opioid dependent mother and newborn dyad: non-pharmacologic care (J Addict Med. 2008 September 1; 2(3): 113–120.)
    a. This study posits that pregnant and postpartum people dependent on opioids, along with their infants, need detailed and tailored care from multiple specialists. While methadone treatment during pregnancy improves outcomes for these parents, it can lead to Neonatal Abstinence Syndrome (NAS) in their babies, causing issues with feeding, sleeping, and communication. Addressing both the mother's and infant's needs through comprehensive assessments and interventions can enhance their interactions and support the infant's development.
7. Reconceptualizing non-pharmacologic approaches to Neonatal Abstinence Syndrome (NAS) and Neonatal Opioid Withdrawal Syndrome (NOWS): A theoretical and evidence-based approach. Part II: The clinical application of nonpharmacologic care for NAS/NOWS (Martha L. Velez, et al.,Neurotoxicology and Teratology 88 (2021) 107032)
    a. This study highlights the need to develop self-regulation skills in both caregivers and children, as these skills are crucial for healthy development. For infants exposed to prenatal stressors or substances, like those with Neonatal Abstinence Syndrome (NAS) or Neonatal Opioid Withdrawal Syndrome (NOWS), effective non-medical care that considers their specific needs and development is essential, as current methods may not adequately address individual variations and can lead to inappropriate treatment or caregiver misunderstanding.
8. Pregnant, Addicted and Fighting the Pull of Drugs (*New York Times*, Jun. 2024)
    a. Michigan program using a harm reduction framework to provide prenatal care to pregnant people using substances.
9. After My Brother's Overdose Death, Misinformed People Added to Our Grief (*New York Times*, Aug. 2024)
    a. Op-ed written by a physician about the dangers and long-lasting harm of fentanyl misinformation.
10. States find a downside to mandatory reporting laws meant to protect children
    a. NPR article giving a brief history of mandated reporting,
11. Mandatory Reporting Task Force 50-State Policy Scan: Mandatory Reporting Occupations in Statute
    a. The Mandatory Reporting Task Force examines national best practices for mandatory reporting policies, and the Colorado Child Protection Ombudsman has created a resource listing which groups are required to report in each state, with simplified information for easier comparison. This document is intended as a starting point for understanding and comparing mandatory reporting laws across states, though it may not include all details or updates.
        i. Nevada is the only state that specifically names doulas as mandated reporters
12. Babies don't come with instructions. But in Oregon, they now come with a nurse

a. NPR article showcasing a pilot program in Oregon that funds 1 -3 postpartum nurse at home visits free for a family with a newborn. Officials are currently working on getting the program funded by insurance. Meanwhile it is a big success, albeit costlier than expected due to promoting the program statewide and from the acute shortage of nurses in Oregon compared with most other states.

13. Washington governor signs new law keeping drug possession illegal (*CNN*, May 2023)
    a. CNN article discussing Washington Governor Jay Inslee signing SB 5536 into law in 2023, which maintains penalties for drug possession while increasing funding for addiction treatment and recovery services. Through diversion programs in the court system, the law aims to balance accountability and support for those struggling with addiction, while eluding a full decriminalization of drug possession in the state.
        i. Fentanyl use is as at the forefront of discussion, as according to the CDC, nearly "*70,000 people in the US died of drug overdoses that involved fentanyl in 2021, almost a four-fold increase over five years*"
14. Advocates warn new CPS drug law may harm families (*Real Change*, Apr. 2024)
    a. Washington's new law, SB 6109, allows Child Protective Services (CPS) to intervene more in cases where caregivers struggle with substance use disorders and boosts funding for training and addiction treatment. Critics argue that this could lead to more family separations, disproportionately affecting marginalized communities, despite the law's intent to address the rising impact of synthetic opioids like fentanyl on young children.
15. Fentanyl-related deaths among children increased more than 30-fold between 2013 and 2021 (*CNN*, May 2023)
    a. Article detailing how the fentanyl-related overdose deaths among children and teens in the US have surged dramatically, with more than 5,000 deaths over the past two decades, and a significant increase occurring during the COVID-19 pandemic. The rise is especially stark among older teens who use fentanyl-laced drugs, while younger children often die from accidental exposure to fentanyl in the home.
16. WA State Opioid Response Plan 2021-2022 (WA HCA, et. al. 2023)
    a. The effects of substance, opioid, and stimulant use pose a public health challenge that touches the lives of every Washingtonian. Communities across the state have demanded a coordinated response to the persistent and evolving epidemic of drug-related harms. The 2021-2022 Washington State Opioid and Overdose Response Plan is an update to the 2018 Washington State Opioid Response Plan and reflects necessary changes to establish a flexible planning structure that can address substance use needs as they evolve and emerge.
17. The role of doulas in supporting perinatal mental health – a qualitative study (Quiray J, Richards E, Navarro-Aguirre Y, Glazer D, Adachi J, Trujillo E, Perera D, Garcia EP and Bhat A; 2024) The role of doulas in supporting perinatal mental health – a qualitative study. Front. Psychiatry 15:1272513. doi: 10.3389/fpsyt.2024.1272513Feb 2024)
    a. This study found that doulas, who provide emotional and practical support during pregnancy and postpartum, can positively impact mental health support for their

clients, especially in underserved communities. While doulas are generally seen as helpful and culturally attuned, they would benefit from more training and resources to effectively address perinatal mental health and substance use issues.

18. Maternal Infant Health proposal for a Maternal Infant Health Community (Department of Health 202325; Regular Budget Session Policy Level PZ Maternal Infant Health)
    a. Rectifying the opioid crisis is complicated and needs many different groups to work together. Extending the timeline for using funds would lead to higher quality training for healthcare workers, efforts to reduce stigma, and resources to improve support for people with substance use disorders, especially pregnant and parenting people.